Chapter 5

Health Records

Section I

5–1. Purpose of the health record

.*a.* The HREC includes both the treatment record and the dental record. It is a permanent and continuous file that is initiated when a member enters the service. The HRECs are kept in separate folders and are prepared as the member receives medical and dental care or takes part in research.

.*b.* The primary purpose of the HREC is to provide a complete, concise medical and dental history of everyone in the Active Army or in the RC. The HREC is used for patient care, medicolegal support, and research and education. The HREC helps medical officers advise commanders on retaining and using their personnel. It helps physical evaluation boards (PEBs) appraise the physical fitness of Army members and eligibility for benefits. In the case of USAR and ARNGUS, it assists in the mobilization process. The HREC also serves other purposes. For example, it simplifies the adjudication of claims and is an important source of medical research information. The dental portion (panogram) can be used to assist in identifying deceased persons.

5–2. Use of the health record

a. General. Throughout the person's military career, each contact with the AMEDD as a patient is recorded in the HREC. These contacts include periods of treatment as an inpatient and are described on copies of DA Form 3647 (or CHCS automated equivalent) and SF 502 (Medical Record-Narrative Summary), possibly SF 515 (Medical Record-Tissue Examination) and SF 516 (Medical Record-Operation Report), or any other inpatient documents that the physician or dentist deems necessary for proper outpatient follow-up care. Duration and treatment quarters referrals, outpatient medical care, and dental care are all recorded. Medical care at MTFs or DTFs that do not keep the HREC is recorded and sent to the HREC custodian.

b. Use in outpatient medical care.

.(1) Each time the person seeks care or is treated, the HREC or dental record will be removed from the file and used by the health-care provider. The findings and treatment will be recorded on the proper forms.

.(2) When an MTF or DTF refers a patient elsewhere for outpatient care, the HREC may be sent also. The referring or the consulting practitioner makes this decision. If it is sent, the consulting practitioner will comment in the record on his or her findings and treatment. If it is not sent, the consulting practitioner will enter his or her findings on SF 513 or any other medical forms (including SF 600) that he or she deems proper. These consultation (SF 513 or DD Form 2161) and treatment records will be filed in the HREC. (See also para 9–12*d*.)

.(3) See paragraph 1–4*e*(3) for information on when a person reports for outpatient treatment to an MTF or DTF that does not keep his or her HREC.

.*c.* Use in inpatient medical care.

.(1) Normally, the HREC will be sent to the MTF when a person is admitted for treatment. (See paras 5–33 through 5–36 for information on patients from combat areas.) When an MTF receives an HREC, or a part of it, the patient administrator becomes the custodian and will ensure that it is accessible to AMEDD personnel. When received, the HREC will be sent to the patient's ward. It will be kept there during the patient's stay for use by the attending physician or dentist and other medical personnel involved in the case. The patient administrator will ensure that a copy of each of the forms required for the HREC prepared by the MTF are put in the HREC (para 5–3) and that the entries needed for inpatients on SF 600 are made. (See para 5–18.)

.(2) When inpatient dental care is given, MTF dental personnel will try to obtain the patient's dental record. If it is not accessible, a temporary dental record will be prepared as described in paragraph 5–27*b*; the record will be sent to the proper custodian when the patient is released from the MTF. Any other necessary inpatient records will also be completed. Prolonged treatment for a dental condition (for example, fracture) will not be recorded in detail in the dental record; in most cases a brief summary of the diagnosis, general treatment, and results is sufficient. However, any extractions, restorations, or other oral or dental treatment rendered must be entered on SF 603 (Health Record-Dental) of the permanent or temporary dental record.

.(3) When a patient is released from the MTF, the patient administrator will forward the HREC as described in *(a)* through *(h)*, below.

.*(a)* Attached patients RTD. Send the HREC to the record custodian of the MTF or DTF that provides the person with primary outpatient or dental care. If the MTF is not known, send the HREC to the MEDDAC or DENTAC or MEDCEN commander of the person's assigned installation.

.*(b)* Assigned patients RTD. Send the HREC to the military personnel officer of the person's assigned unit. If the person is locally reassigned, send the HREC to the custodian as in *(a)*, above.

.*(c)* Patients transferred to another MTF. Send the HREC with a copy of the inpatient record to the other MTF.

.*(d)* Deceased patients. Send the HREC to the casualty affairs officer holding the patient's personnel file.

.*(e)* Patients transferred to VA Medical Centers. Send the HREC to the correct center. Also send a copy of the patient's inpatient records unless they have been sent to the PEB for examination (AR 635–40).

(f) Other patients separated from service. Send the HREC to the military personnel officer handling the separation at the transition point. He or she will dispose of them as stated in paragraph 5–29.

(g) Patients AWOL longer than 10 days. Send the HREC to the officer holding the person's personnel file.

.*(h)* RC patients in the Active Army or on Active Guard Reserve duty. Send the HREC to the unit health record custodian.

5–3. For whom prepared and maintained

HRECs will be prepared and maintained for all Army members. This includes Active Army and RC members, and cadets of the U.S. Military Academy. ARNGUS and USAR HRECs will be prepared and maintained by the custodian of the personnel files. (These HRECs will be prepared in accordance with paragraph 4–1, but they will be filed in alphabetical sequence.) When transferred to Army custody, HRECs for members of the Navy and Air Force will also be maintained. HRECs for military prisoners will be kept as

long as they are confined in US military care facility.

5–4. Forms and documents of health records

.a. The medical and dental forms authorized for use in the HREC are listed in figures 5–1, 5–2, and 5–3. To facilitate access to information in these folders, the forms will be filed from top to bottom in the order listed in the figures. Forms will be filed in reverse chronological order, that is, the latest on top. (For authorization of forms and overprinting, see paras 3–1 through 3–3.) The forms listed in figures 5–1 through 5–3 are available either electronically or through normal publications supply channels.

.b. The folders of USAR and ARNGUS members on active duty for training will be marked "ADT" on the front. The forms inside the folder will be given the same marking in the lower margin. Folders of Active Guard Reserve members will be maintained in the same manner as those in the Active Army.

5–5. DA Form 5007A and DA Form 5007B

DA Form 5007A (Medical Record-Allergy Immunotherapy Record-Single Extract) and DA Form 5007B (Medical Record-Allergy Immunotherapy Record-Double Extract) will be used to document hyposensitization injections as prescribed on SF 559 (Medical Record-Allergen Extract Prescription, New and Refill). DA Form 5007A is intended for patients on single injection immunotherapy, while DA Form 5007B is intended for patients on two separate immunotherapy prescriptions. These forms are available on the Army Electronic Library (AEL) CD–ROM and the USAPA Web site, www.usapa.army.mil.)

5–6. DA Form 5008

DA Form 5008 (Telephone Medical Advice/Consultation Record) will be used to record medical advice or consultation given to a patient over the telephone. Self-explanatory instructions for completion are on the back of DA Form 5008. This form is attached to SF 600 when filed.

5–7. DA Form 5181

DA Form 5181 (Screening Note of Acute Medical Care) will be used in conjunction with the Enlisted Screener Program in battalion aid stations and troop medical clinics. This form is available on the Army Electronic Library (AEL) CD–ROM and the USAPA Web site, www.usapa.army.mil.

5–8. DA Form 5569

DA Form 5569 (Isoniazid (INH) Clinic Flow Sheet) will be used to document Isoniazid (INH) clinic visits. This form is available on the Army Electronic Library (AEL) CD–ROM and the USAPA Web site, www.usapa.army.mil.

5–9. DA Form 5570

DA Form 5570 (Health Questionnaire for Dental Treatment) will be used in the dental record as the medical history questionnaire. This questionnaire is printed on an envelope used to contain dental radiographs.

5–10. DA Form 5571

DA Form 5571 (Master Problem List) will be used instead of DD Form 2766 for pediatric patients. The form will be filed in the OTR to provide a summary of significant past surgical procedures, past and current diagnoses or problems, and currently or recently used medications.

5–11. DD Form 1380

DD Form 1380 (U.S. Field Medical Card) will be used as described in chapter 11 and paragraph 5–33 (as an HREC document under combat conditions). Instructions for the use and preparation of DD Form 1380 are provided in chapter 11.

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5–12. DD Form 2482

DD Form 2482 (Venom Extract Prescription) will be used to order a venom extract prescription. One venom prescription (new or refill) will be ordered on each DD Form 2482. DD Form 2482 is not designed for multiple prescription orders.

5–13. DD Form 2766 and DD Form 2766C

a. DD Form 2766 replaces—

.(1) DA Form 5571 (Master Problem List) for active duty, U.S. Army Reserve (USAR), and Army National Guard of the United States soldiers (ARNGUS), non-active duty adult beneficiaries, and civilian employees.

.(2) DA Form 8007–R (Individual Medical History) for active duty, USAR, and ARNGUS soldiers, and deployable civilian employees.

.(3) SF 601 (Health Record-Immunization Record) for active duty, USAR, and ARNGUS soldiers. SF 601 will continue to be used for non-active duty adult beneficiaries, and non-deployable civilian employees.

.b. DD Form 2766 is available in two constructions (folder and cut sheet). Both constructions are available through normal publishing channels.

.(1) The folder construction will be used for active duty, USAR, and ARNGUS personnel and for deployable civilians. During normal use, the folder is placed on the fasteners inside the existing DA Form 3444-series or DA Form 8005-series treatment folders. (See figs 5–1 and 5–2.) During deployments, the DD Form 2766 will be removed

from the treatment folder and accompany the individual to the field. (See para 5–32.)

.(2) The cut sheet construction will be used for non-active duty adult beneficiaries (those 18 years of age and older) and non-deployable civilians; this version consists of pages 1 and 2 only. Documentation of immunizations for these individuals will continue to be done on SF 601; if an automated immunization tracking system is in place, a printout from this system may be used instead of using an SF 601. (The provider will authenticate the printout by reviewing and signing over a printed or stamped signature block before the printout is placed in the medical record.) File the cut sheet construction according to figures 6–1 and 6–2.

.c. All information documented in the medical record is considered a part of the legal document. Superseded forms such as DA Form 5571 and DA Form 8007–R will not be discarded from the medical record at any time.

.(1) With the initiation of DD Form 2766, information from the current DA Form 5571 and DA Form 8007–R will be transcribed onto DD Form 2766. Ink is required except in block 8 (para *d*(9), below), the "ordering exam" section, which is explained in the use of block 7 (para *d*(8), below), and the annotation of dosage, frequency, and purpose of significant or long-term medications, which is discussed in block 3 (para *d*(4), below).

.(2) If data is transcribed from DA Form 5571 or DA Form 8007–R, a line will be drawn through the information and the word "Transcribed" will be written along the line with the date, full name, and rank of the transcribing individual.

.(3) The DA Form 5571 and DA Form 8007–R will remain with the medical record and be placed behind the current DD Form 2766 and the Health Enrollment/Evaluation Assessment Review (HEAR) Primary Care Manager (PCM) Report (when available). (See figs 5–1, 5–2, 6–1, and 6–2.)

.d. Instructions for completion of DD Form 2766 are as follows. Paragraphs (9) through (12), below, apply only to the folder construction.

.(1) Identification data.

.(a) Put an identification label in the "Patient Identification" block. (See (para 4–4*b*(1).) Instead of this label, the patient’s recording card may be used to stamp the form. Enter the individual’s religion, race, and military occupational specialty or area of concentration along the bottom edge of this block.

.(b) Legibly print the other requested identification data.

.(c) For the folder construction, enter the SSN in the hyphenated blocks along the top of the folder; enter the family member prefix in the circles to the left of these blocks.

.(2) Block 1–Allergies. Write the medication and other types of allergies within the area noted. Enter one of the following statements:

.(a) Medical Warning Tag issued on (date); or

.(b) Medical Warning Tag not issued.

.(3) Block 2–Chronic Illnesses. List chronic illnesses.

.(4) Block 3–Medications. In ink only, list the drug name and initiation date of significant or long-term medications. Do not include medications prescribed for acute illness or other short-term indications. Annotation of dosage, frequency, and purpose is optional and may be made in pencil to allow for adjustments. Line through long-term medications when discontinuing them.

.(5) Block 4–Hospitalizations/Surgeries. List hospitalizations and all surgeries, including dates.

.(6) Block 5–Counseling. The "Date," "Age," and "Topic" fields are intended to be filled in at the annual preventive assessment (for example, TRICARE Prime enrollment, or Preventive Health Assessment, POM, POR, or SRP, or when the HEAR is evaluated and the patient is counseled). Counseling is listed from general to specific. Place the letter

associated with the type of counseling given in the corresponding "Topic" block (for example, "F" for Fitness). When all preventive health topics are addressed, write "all areas addressed" in the "Topic" block. Circle the letter that corresponds to the individual's high risk profile. Extra blocks are provided for documentation of "outstanding" high risk preventive counseling accomplished at times other than the annual assessment (for example, alcohol abuse, mental health concerns, and so forth). This block is NOT to be used at every visit-document counseling initiatives on SF 600 (Medical Record-Chronological History of Medical Care) at every visit. The counseling block is not intended to take the place of quality counseling documentation on the SF 600, or assumed to be an official referral for further education at community-based services.

.(7) Block 6–Family History. In the larger block, fill in the family member's designation (for example, mother, father, and so forth) with the corresponding disease, using the key provided. Specify the types of illness/disease. Document the age of the family member at the time of death if there is a correlation with the illness or disease process.

.(8) Block 7–Screening Exams. Exams are listed from general to specific. The form contains some elements of clinical preventive services and counseling which are mandated only for TRICARE Prime enrollees (for example, annual vision and dental exams). The availability of the full scope of the TRICARE preventive benefits package to other beneficiaries will be in accordance with regional TRICARE contract and local policy.

.*(a)* Fill in the current year and age of the patient in blocks 7c and 7d and continue out for 6 years.

.*(b)* Fill in the circles under the "Dates" field (block 7e) to denote the next date the test is due.

.*(c)* Pencil in the date the exam is ordered.

.*(d)* Use ink when the exam is completed and the results are written on the form.

.*(e)* Use the proper key code or write in the actual results in the blocks.

.*(f)* Update DD Form 2766 every time preventive care is ordered or performed, or results are returned.

.(9) Block 8–Occupational History/Risk. Check the appropriate box in pencil and list the exposure hazards as needed.

.(10) Block 9–Immunizations.

.*(a)* Ink, sticker, rubber stamp, or automated documentation is required. The date and type of immunization must be recorded. Titers will be documented by the date and result, using the corresponding date square.

.*(b)* Open data spaces are present to allow for flexibility of this form (for example, in case an injection or titer is required that is not presently listed).

.*(c)* In accordance with the National Vaccine Injury Compensation Program, appropriate vaccine information must be recorded (according to Service-specific

regulatory guidance, AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E, and HHS Form PHS 731 (International Certificate of Vaccination) for all personnel. The date square may be filled in by hand, stamp, sticker, or via automation in order to comply with national regulations. If documentation of the date and lot number are recorded in the medical record, it does not have to be duplicated on the DD Form 2766. Attach the existing SF 601 to the fastener in the folder. MTFs may also use bar-coding to log in the lot information into their automated system.

.*(d)* If an automated immunization tracking system printout is available, immunization information does not have to be transcribed by hand onto the DD Form 2766. Instead, attach the automated printout to the fastener in the folder.

.(11) Block 10–Readiness. Enter the required information and the dates in the appropriate spaces.

.*(a)* The date that the DNA blood sample was taken will be copied from the SF 600 that is completed when the sample is drawn (para 5–18*j*).

.*(b)* The optometry prescription will be written directly below the "Glasses/Gas Mask" description block. Changes of the prescription may be documented within the date block as needed. One of the blank fields may also be used for this information.

.*(c)* If pregnancy is a possibility, use one of the blank spaces to write in the results of a pregnancy screen prior to deployment.

.(12) Block 11–Pre/Post Deployment History.

.*(a)* Except for classified operations, document the deployment location as well as the completion date of the pre-and post-deployment evaluations. For classified operations, the record of deployment location will be maintained only in the personnel folder, along with any required pre- and post-deployment evaluations such as DD Form 2795 (Pre-Deployment Health Assessment) and DD Form 2796 (Post-Deployment Health Assessment).

.*(b)* The "Chart Audit" block (11c) is reserved for official inspections by JCAHO and for military inspections. Place the audit date in the designated square.

.*e.* DD Form 2766C (Adult Preventive and Chronic Care Flowsheet-Continuation Sheet) may be used as a continuation sheet for either construction or for local requirements such as chemoprophylaxis.

.(1) For example, if personnel run out of space for deployment history in the six fields in block 11, data fields on DD Form 2766C can be changed to reflect the type of information required.

.(2) Document the use of any chemoprophylactic agents on DD Form 2766C.

.(3) When DD Form 2766C is used as a continuation form for the DD Form 2766 folder, file it by placing it on the fastener on the right side of the folder (figs 5–1 and 5–2.). When this form is used as a continuation form for the DD Form 2766 cut sheet, file according to figures 6–1 and 6–2.

5–14. DD Form 2813

DD Form 2813 (Department of Defense Reserve Forces Dental Examination) is used to obtain the dental health status of members of the Reserve Components for deployment readiness. The form will be completed by members' civilian dentists and provided to the members' military organization for entry into an electronic tracking system.

5–15. SF 512

SF 512 (Clinical Record-Plotting Chart) will be filed in HRECs, OTRs, CEMRs, and ITRs to record cholinesterase levels and any single item deemed clinically significant. SF 12 will be filed immediately above SF 545.

5–16. SF 558

.a. SF 558 (Medical Record-Emergency Care and Treatment) will be used instead of SF 600 to record all care provided to patients in the emergency center/emergency department (EC/ED). Self-explanatory instructions for completion are on the back of SF 558.

.b. When the patient is admitted as an inpatient through the EC/ED, SF 558 will be the admission note filed in the patient's ITR. Whenever possible, a notation should be made on SF 600: "Patient admitted to (name of MTF), (date)." A copy of any State ambulance forms will be filed with the SF 558 in the ITR.

5–17. SF 559

SF 559 will be used when an allergen extract prescription is ordered. One treatment set or refill prescription will be ordered on each form. SF 559 is not designed for multiple prescription orders.

.a. Use the patient's recording card to complete the patient's identification block in the lower left corner of SF 559 (para 3–5*a*). In all cases, give the patient's full name, sponsor's SSN, and appropriate FMP (table 4–1). Provide the patient's name, address, and phone number in the space provided on SF 559.

.b. The address of the medical facility to which the prescription is to be sent must be given because it may differ from that of the prescribing MTF.

.c. The front of SF 559 may be overprinted with the allergenic extracts most commonly prescribed for hyposensitization treatment (immunotherapy) in the geographic region. MTFs may overprint this information without submitting it to Office of The Surgeon General for approval. From top to bottom, left to right, overprint in the following order: trees, grasses, weeds, molds, environmentals, insects, and miscellaneous. List complete antigenic components, and state the volume in milliliters (mL) of those components in the final mixture. The volume must add up to a final volume of 10 mL including diluent. State the volume of diluent in mL in the space provided. The volume of refill vials will also be 10 mL. State the concentration of the allergenic components in protein nitrogen units/mL, weight/volume, or allergy units/mL. On the second line of the front page, state the strength of the described most concentrated vial. For example, 20,000 protein nitrogen units/mL, 1:100 weight/volume, or 10,000 allergy units/mL. Immediately below the allergen contents section, annotate the vial numbers of the most dilute and most concentrated vials.

.d. Complete the section on the lower front page for refill requests only. In addition, all subsequent portions of SF 559 must be completed as they would on the initial treatment set, including the recommended treatment instructions and responsible physician's signature.

.e. Start the treatment instructions with the lowest numbered vial, listing one vial on each line. Give the strength of each vial from the line corresponding with that schedule.

.f. In general, schedule A provides for the most rapid dosage progression, with each schedule through E being progressively more gradual.

.g. SF 559 must be signed by the ordering physician. A signature card must be on file for the prescribing physician at the U.S. Army Centralized Allergen Extract Laboratory, Walter Reed Army Medical Center, Building 512, Forest Glen Annex, Silver Spring, MD 20910.

5–18. SF 600

SF 600 will be used only in the HRECs, OTRs, CEMRs, and ASAP–OMRs. It is the chronological record of outpatient treatment and thus is the basic form of the HREC. The MTF initiating an SF 600 will complete the identification data at the bottom of the form. Entries on the form may be typed, but they will usually be written in ink; if written, entries must be legible. Each entry will show the date and time of visit and the MTF involved; these entries will be made by rubber stamp when possible. (As long as the patient is treated by the same MTF, the name of that MTF need not be repeated in every dated entry.) Each entry on the form will also be signed by the person making it (para 3–4*c*). (See fig 5–5 for examples of entries on SF 600.)

a. SF 600. One copy of SF 600 will be put in the HREC. The parts of the form to be completed are shown in (1) through (8), below. These entries will be either typed or printed. If printed, permanent black or blue-black ink will be used.

.(1) Person’s name.

.(2) Sex.

.(3) Year of birth.

.(4) Component. (Do not include branch.)

.(5) Department.

.(6) Rank.

.(7) Organization.

.(8) SSN.

.b. Entries for outpatient care.

.(1) Entries must be concise but complete, that is, medically and adjudicatively adequate. Entries will—

.(a) Describe the nature and history of the patient’s chief complaint or condition.

.(b) Record positive and pertinent examination or test results.

.(c) Record diagnoses and impressions (if made).

.(d) Record treatment, disposition, and any instructions given to the patient for later or follow-up care; record all prescribed drugs. These entries may be recorded in a "subjective, objective, assessment, plan" (SOAP) format.

.(2) Record each visit and describe the complaint even if the patient is RTD without treatment. If a patient leaves before being seen, this fact will also be stated.

.(3) When admission as an inpatient is imminent, the entries discussed in (1) above may be made on SF 509 instead of SF 600. SF 509 will be the inpatient admission note filed in the patient’s inpatient record. For EC/ED admissions, see paragraph 5–16*b*. Record other referred or deferred inpatient admissions on SF 600.

.(4) Record all requests for consultation, prescriptions, or other services on SF 600.

.(5) For patients seen repeatedly for special procedures or therapy (for example, physical and occupational therapy, renal dialysis, or radiation), note the therapy on SF 600, and record interim progress statements. In addition, give a final summary when the special procedures or therapy are ended. This summary will include data shown in *(a)*

through *(h)*, below. Initial notes, interim progress notes, and any summaries may be recorded on any authorized form, but they must be referenced on SF 600.

.*(a)* Results of evaluative procedures.

.*(b)* Treatment given.

.*(c)* Number of visits.

.*(d)* Reaction to treatment.

.*(e)* Progress noted.

.*(f)* Condition on discharge.

.*(g)* Instructions to patient.

.*(h)* Any other pertinent observations.

.(6) If an injury is treated, the cause and circumstances ("how-when-where-leave status") will be entered.

.(7) For persons taking part in research projects as test subjects, entries will include—

.*(a)* Drugs given or appropriate identifying code.

.*(b)* Investigative procedures performed.

.*(c)* Significant observations, including effects.

.*(d)* Physical and mental state of the subject.

.*(e)* Tests and laboratory procedures performed.

.(8) Outpatient care received at civilian facilities will also be recorded on SF 600. If available, copies of records of such care will be put in the HREC. Any forms completed at civilian facilities will be filed with SF 600.

.*c.* Entries for periods of medical excuse from duty. Except in combat, each admission to an MTF or referral to quarters will be recorded on SF 600.

.(1) In addition to the information described in *a*, above, entries for MTF admissions will include—

.*(a)* Time and date of admission.

.*(b)* Name and location of the MTF.

.*(c)* Cause of admission.

.(2) In the case of referral to quarters, detailed comments will include—

.*(a)* Care given.

.*(b)* Estimated duration.

.*(c)* Extensions of quarters status.

.*(d)* Instructions to patient.

.*(e)* When the patient will be RTD.

.*(f)* Laboratory, x ray, consultation, and similar reports.

.*d.* Entries for physical examinations. "Physical Examination" and the date will be entered on SF 600 for each complete physical examination made and recorded on DD Form 2808. Entrance medical examinations will not be entered.

.*e.* Entries for orthopedic footwear. When a person is authorized the issue of orthopedic footwear, the term "orthopedic footwear authorized" will be entered on SF 600, as well as the prescription and date.

.*f.* Entries for board proceedings. When copies of PEB or medical board proceedings are put in the HREC, the insertion of the copies in the record, the date it was done, and the date of the board proceedings will be noted on SF 600.

.*g.* Entries for treatment of sexually transmitted diseases. The preparation of SF 602 (Medical Record-Serology Record) and the date it was done will be noted on SF 600.

Later information recorded on the SF 602 will not be noted on SF 600.

.h. Entries for substance abuse treatment. When a person has been determined by clinical evaluation to be a substance abuser, entries will be made on the SF 600, which will be filed in the HREC.

.i. Entries for a pregnancy diagnosis. After a pregnancy, all forms related to it will be filed in the ITR. When the records are filed, the following information will be entered on SF 600: "Prenatal care records filed in ITR of (patient's name, FMP, and SSN), (location of MTF), (date)." If the pregnancy is not concluded at an MTF, a notation will be made on the prenatal forms and they will be filed in the HREC.

.j. Entries for DNA blood samples. An entry will be made on an SF 600 when a blood sample is taken for DNA identification. The SF 600 will be stamped with the date, the time, and a DNA stamp, and then filed in the HREC. The date when the sample was taken will be entered in block 10a of DD Form 2766.

5–19. Immunization documentation (DD Form 2766, SF 601, and HHS Form PHS 731)

Active duty, USAR, and ARNGUS soldiers and deployable civilians will have their immunizations documented on DD Form 2766. (Non-active duty adult beneficiaries and non-deployable civilians will have their immunizations documented on SF 601 (para 6–7*b*(1).) HHS Form PHS 731 (International Certificates of Vaccination) is a personal record of immunizations received; it is normally needed for international travel. Usually, Active Army and USAR members have custody of their HHS Form PHS 731; they will ensure their safekeeping. HHS Form PHS 731 for RC personnel are usually issued to the person for custody upon mobilization or when traveling internationally. ARNGUS units may retain HHS Form PHS 731.

.a. DD Form 2766. At reception stations, procedures will be established to ensure that immunization information is entered on DD Form 2766. For persons allergic to medication, the "Medical Condition" block on the front of the HREC folder will be checked and block 1 on DD Form 2766 will be annotated. In addition, DA Label 162 will be placed on the HREC folder and DD Form 2766 according to chapter 14. Paragraph 5–13*c*(10) contains instructions for documenting immunizations in block 9 of DD Form 2766.

.b. HHS Form PHS 731. A copy of HHS Form PHS 731 will be sent with the HREC for later entries of immunization data. If the military member prefers, the HHS Form PHS 731 may be clipped or fastened to DD Form 2766; it will not be punched like permanent documents in the record. The name and SSN of the person will be typed or written in ink on the front of the form. For officers and warrant officers, the form will be addressed to the Commander, PERSCOM, ATTN: TAPC–POR–R, Alexandria, VA 22332–0002. For enlisted personnel, the form will be addressed to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE–RP, 8899 East 56th Street, Indianapolis, IN 46249–5301. The name of the person's unit will be entered below the double line at the bottom of the form; it will not be entered until he or she reaches his or her first training or duty station.

c. Tasks.

.(1) The unit commander will ensure that each assigned or attached member receives the immunizations required by AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E. The commander will periodically check the immunization status of each unit member and consult with the local medical officer to ensure that immunizations are given when due.

.(2) The brigade surgeon, or his or her designee, acting on behalf of the commander, will notify members that immunizations are needed according to the schedule in AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E.

.(3) The medical officer will check the accuracy of the entries on DD Form 2766 and HHS Form PHS 731 as well as administer, record, and properly authenticate required immunizations.

d. Authentication of entries. In accordance with international rules, entries on HHS Form PHS 731 for immunizations against smallpox, yellow fever, and cholera will be authenticated. Each entry must show the DOD Immunization Stamp and the signature of the medical officer or his or her chosen representative (AFJI 48–110/AR 40–562/ BUMEDINST 6230.15/CG COMDTINST M6230.4E). For other entries on HHS Form PHS 731 and entries in block 9 of DD Form 2766, the signature block may be stamped or typewritten and authenticated by initialing.

e. Entries.

.(1) Immunizations and sensitivity tests will be recorded on DD Form 2766. Rubella titre results must be recorded on DD Form 2766. Rubella immunizations must be entered on both DD Form 2766 and HHS Form PHS 731.

(2) Remarks and recommendations for any entries on DD Form 2766 may be added at the MTF. The reasons for waiving any immunization will be recorded in enough detail for later medical evaluation. Any attacks of diseases for which immunizing agents were used must be noted; the year and place of attack must also be given. Any untoward reactions to immunizations (including vaccines, sera, or other biologicals) will be recorded.

.f. Loss of DD Form 2766 or HHS Form PHS 731. If a HHS Form PHS 731 is lost, a duplicate will be made by transcribing the information on DD Form 2766. If a DD Form 2766 is lost, a duplicate will be made by transcribing HHS Form PHS 731. If both forms are lost, new forms will be prepared.

.g. Disposition on separation from service. When released from active duty or separated from the service, personnel will be encouraged to keep their HHS Form PHS 731 for future use.

5–20. SF 603 and SF 603A

SF 603 is the basic form used in the HREC and dental record to document the oral status, oral health care, and oral or dental treatment provided in a DTF and MTF. SF 603A (Health Record-Dental Continuation) is the related form used as a continuation sheet when space on SF 603 is full.

a. One copy of SF 603 will be inserted in the dental record. The identification parts of this form will be completed as described for SF 600 in paragraph 5–18.

.(1) Personnel entering active service or active duty for training for more than 30 days.

All such personnel will have a panographic radiograph of the teeth and surrounding tissues taken. The radiograph will be taken during inprocessing. If a panographic x ray capability is unavailable, the radiograph will be taken as soon as possible. This radiograph will be used for identification. In addition, these personnel will be inspected for disqualifying dental defects. (Determination of disqualifying dental defects will be made by a dental officer.) Except as indicated in *(d)*, below, charts 4 and 5 in section I of SF 603 will no longer be used to record any dental defects that are found; chart 16 in section III of SF 603 will be used.

.(2) Personnel reentering military service. A new SF 603 will be completed for personnel reentering active service.

.(3) Personnel discharged or released from full-time duty in the military (active service). When a military member has received a complete dental examination and all dental services within 90 days before discharge or release, the remarks section of the SF 603 will include the following statement: "The member was given a complete dental examination on (date) and all dental services and treatment indicated by the examination have been completed." (The statement may be stamped, and the date block filled in and initialed.) The officer in charge of the DTF will ensure that the dental records of all personnel being discharged or released from active service are reviewed.

.(4) Personnel entering active duty for training for 30 days or less. USAR, ARNGUS, and members who enter initial active duty for training for 30 days or less and those who have no active duty training obligation (for example, direct appointment ARNGUS and USAR AMEDD officers) or those individuals without a panographic x ray (initial entry service was prior to this policy) will have a dental record initiated. The dental records portion of the HREC will contain, at a minimum, an SF 603 with section I (items 1 through 4) and section II (items 6 through 14) completed. This information will be used for identification. This examination should be performed by dental officers of the RC who are not on active duty.

.b. All dental treatment given to an individual after initiation of his or her dental record will be recorded in the correct section of SF 603 or SF 603A. Detailed instructions on completing SF 603 and SF 603A are provided in (1) through (5), below, and in TB MED 250.

.(1) General information. The front side of SF 603 is used to initiate a dental record. It contains complete patient identification information and a series of dental charts. The back side of SF 603 is the same as SF 603A. SF 603 and SF 603A are used to record dental treatment and simple treatment plans.

.(2) SF 603, section I.

.(a) Section I is used to record missing teeth, existing restorations, diseases, and abnormalities when a dental record is initiated. Part 5 of section I may be used to chart initial treatment needs.

.(b) Part 4 of section I is charted in ink, using the symbols discussed in TB MED 250, when initial dental processing is performed and there is no panographic radiograph capability. A panograph must be added to the record at the earliest possible time. Any abnormalities that cannot be charted using the graphic chart and symbols discussed will be noted in the "Remarks" section.

.(c) The entry will be dated, place of examination will be recorded, and the dental officer doing the examination will sign. Because this chart may have to be used for

forensic identification purposes, restorations drawn in this section must accurately portray the restoration in the mouth.

.(3) SF 603, section II.

.*(a)* Permanent entries. The following entries are made by the military personnel officer or by the DTF. Entries will be typewritten or printed in permanent black ink. Sex (item 6); Enter M for male or F for female. Race (item 7); This entry is optional. If it is used, enter Cau for Caucasian, Bl for black, Oth for a member of any other race, and Unk for unknown. Component or Branch (item 10); Enter the applicable code according to TB MED 250. Service, Dept, or Agency (item 11); Enter Army, Navy, Air Force, etc., or whatever Service, department, or agency to which the sponsor belongs. Patient's Name and Date of Birth (items 12 and 13); Self-explanatory. Identification No. (item 14); Enter the SSN of military personnel (active and retired). For family members, enter the FMP followed by the sponsor's SSN.

.*(b)* Temporary entries. The entries in section II will be made in number 1 or 2 pencil by the military personnel officer or by the DTF. The dental record custodian will make changes as they occur. See TB MED 250.

.(4) SF 603 and SF 603A, section III.

.*(a)* Block 15. This part of the SF 603 and SF 603A is used to record restorations and treatment of defects performed after the initial dental processing. Entries are made in black ink. The remarks block normally requires no entries. It should be annotated, however, if there is a significant item in the medical history and should detail that item.

.*(b)* Block 16. This part of SF 603 and SF 603A is an examination chart. It is used to record those defects which are discovered at the time of initial and subsequent examinations. Entries are made in pencil and individual entries erased as each related treatment is completed and appropriate entries are made in block 15. Remarks block-Indicate in pencil the date of examination. If the patient is dental class 3, indicate the reason for this classification. This space may also be used by the dentist to sequence simple treatment plans.

.*(c)* Entries in block 17–Services Rendered. All entries will be made legibly in black ink. Entries will include every treatment as well as major steps involved in multivisit treatments. Extensive narrative entries may be entered across the entire page when necessary. Date column-Enter the current year on the first line. Subsequent dates on the following lines will include only the day and month of each treatment visit. When the year changes, enter the new year on the next line. Diagnosis-Treatment column-Treatments should be entered in chronological order as performed during the appointment. Whenever possible, a tabular format for treatments performed should be used. This format greatly aids searching for data about a specific tooth, or area, and speeds record audits. See TB MED 250. Dental fitness classification (in accordance with AR 40–35) is performed at all examinations in which the dental record is present, to include screening examinations, preparation of replacements for oversea movement examinations, and so forth, and is recorded in the "Class" column of block 17 of SF 603 and SF 603A. Fitness classifications apply to active duty members only. Indicate the date of examination in pencil in the Remarks portion of block 16. For Class 3 patients, the reason(s) for placing the patient in Class 3 should be indicated in descending order of

clinical importance. The dental fitness classification will be placed in the Class column of block 17. For active duty personnel the dental fitness classification will be indicated on the outside of the record jacket by colored tape codes. The appropriate tape code will be placed in the space to the left of the "O" block on the upper edge of the back of the record jacket and above the "O" block on the right edge. The name of the facility will be shown in block 17 for the first entry made at that facility. The operator's name, rank, and corps, occupation or degree will be shown for each treatment. Expanded duty assistants must also show the name of the supervising dentist on the last line of entry. Authentication of entries-The care provider will sign or initial all entries and be responsible for the accuracy and completeness of all entries. Entries transcribed from records received from civilian or foreign military facilities will carry the name and signature (or initials) of the person making the transcription.

.(5) SF 603A.

.(a) SF 603A is used as a continuation sheet for SF 603 and will be added to the dental record when there is not enough space for recording treatment or when accumulated entries in the charts of section III, SF 603, become confusing. Entries are made on SF 603A in the same manner as on SF 603. For convenience, any remaining entries in block 16 on the original SF 603 may be carried over to SF 603A. When a new SF 603A is initiated, the patient's last name, first name, middle initial, and identification number must be placed along the right-hand margin where indicated.

.(b) Occasionally a new SF 603A with treatment entries will be added to a record before the previous SF 603 or SF 603A has been filled. In this instance, the empty portion of block 17 on the old form must be rendered unusable so that the proper chronology of the record will be maintained. This task is done by drawing a diagonal line from corner to corner through the unused portion of the two large columns in block 17.

.c. For active duty personnel, any record of oral or dental care provided by personnel who did not have access to the permanent HRECs and dental records (for example, during field operations, from civilian or foreign sources, from other DTF or MTF, and so on) will be transferred to SF 603 or SF 603A in the permanent record, and the original document will be filed in the DA Form 3444-series folder. This task will be accomplished as soon as the temporary records are made available and will be performed by the record custodian or dental providers authorized such entries by the custodian.

5–21. Other forms filed in the health record

a. When the following forms are prepared, one legible copy will be filed in the HREC:

.(1) DA Form 3647 or CHCS automated equivalent.

.(2) SF 502.

(3) If the physician deems necessary for proper outpatient follow-up care, SF 515, SF 509, SF 516, and other physician-designated forms.

.(4) DA Form 199 (Physical Evaluation Board (PEB) Proceedings) (AR 635–40).

.(5) DA Form 3947 (Medical Evaluation Board Proceedings) (AR 40–400).

.(6) DA Form 4707 (Entrance Physical Standards Board (EPSBD) Proceedings) (AR 40–400).

.(7) DD Form 2569 (Third Party Collection Program Insurance Information.)

.b. Copies of other HREC forms will be filed and prepared as described in (1) through

(10), below.

.(1) DD Form 2808, DD Form 2807–1 (Report of Medical History), DA Form 7349 (Initial Medical Review Annual Medical Certificate), and DD Form 2697 (Report of Medical Assessment). The original of each of these forms will be filed; a copy of DD Form 2697 will be sent to the Department of Veteran's Affairs, Records Management Center, P.O. Box 5020, St. Louis, MO 63115–0020 (AR 40–501).

.(2) DD Form 771 (Eyewear Prescription). Each time DD Form 771 is prepared, a copy will be filed permanently in the HREC.

.(3) DA Form 3349 (Physical Profile). When a person's profile serial is revised in accordance with AR 40–501, the original DA Form 3349 will be put in the HREC.

.(4) DA Form 4465 (Patient Intake/Screening Record (PIR)) and DA Form 4466 (Patient Progress Report (PPR)). These two forms will be prepared, kept, and used in accordance with DA Pam 600–85.

.(5) DD Form 1141. DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation) or Automated Dosimetry Records (ADRs) of personnel dosimetry must be kept in the HREC. When a person changes station or leaves the service, these records will be moved with his or her HREC. The dosimetry records of personnel whose work exposes them to ionizing radiation may be removed from their HRECs and filed separately when the medical officer or other authority who keeps and uses the records does not have easy access to the HRECs of these personnel. In these cases, the separate file of dosimetry records will be kept as described in AR 11–9. (See AR 25–400–2, file number 11–9a, personnel dosimetry files, and table 3–1 of this regulation.)

.*(a)* When dosimetry records are temporarily withdrawn from the HREC, file OF 23 in their place. Under the Identification of Record column of OF 23, enter the numbers of the forms removed. In the Charge To column, enter the name of the medical officer (or other authority) borrowing the records and the name and address of the MTF (or activity) where these records will be kept. Enter the date the record is removed in the Date Charged Out column.

.*(b)* OF 23 will not be removed from the HREC until the dosimetry records have been returned.

.(6) DA Form 4186 (Medical Recommendation for Flying Duty). File the most recent DA Form 4186 according to figures 5–1 and 5–2. If the person is granted clearance to fly, file the most recent DA Form 4186 next, if any, that shows a medical restriction from flying. If a waiver has been granted for any cause of medical unfitness for flying, file the most recent DA Form(s) 4186 showing such waiver(s) next. File any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter "Permanent Record" in Remarks section.) Destroy other DA Forms 4186. Block 8b of DD Form 2766 will be updated in pencil to show the current flying status.

.(7) State ambulance forms. By their design and content, State ambulance forms facilitate comprehensive documentation of prehospital treatment and therefore enhance the quality of the hospital medical records in which they are filed. Documentation of prehospital care is required by the JCAHO standards. If a patient is admitted to an MTF, a copy of this form must be placed in the ITR with the SF 558. MTFs that want to continue using local ambulance forms (DA Form 4700 overprints) may do so. The use of State ambulance forms in the OTR is also encouraged.

.(8) DA Form 3180 (Personnel Screening and Evaluation Record) and DA Form 4515 (Personnel Reliability Program Record Identifier) . DA Form 3180 and DA Form 4515 will be used to identify the medical records of individuals qualified for the Nuclear or Chemical Personnel Reliability Programs in accordance with AR 50–5 and AR 50–6. The records manager will insert DA Form 4515 as the top document on the right side of the folder and file DA Form 3180 according to figures 5–1 and 5–2. (See para 5–31.)

.(9) DD Form 2493–1 and DD Form 2493–2. DD Form 2493–1 (Asbestos Exposure Part I–Initial Medical Questionnaire) and DD Form 2493–2 (Asbestos Exposure Part I–Periodic Medical Questionnaire) are required by AR 40–5. For workers initially entering asbestos surveillance programs, Part I is completed. Part II is filled out by individuals who have completed the initial questionnaire and are continuing in an asbestos surveillance program.

.(10) SF 602.

.(a) The medical officer who diagnoses a sexually transmitted disease will prepare SF 602 (original only) on the infected person. Examinations and laboratory procedures used to make the diagnosis will be noted on SF 600 when the case is given outpatient treatment; SF 602 will be completed after the diagnosis is made and therapy is begun. When SF 602 is prepared, the medical officer will enter all identification data at the bottom of the form. A careful history and physical examination will be made; all pertinent findings will be recorded in sections I and II. A detailed account of all treatments and all laboratory studies will be entered in sections III and IV. In section I, the patient will sign and date his or her statement. Section VII of SF 602 will not be used.

.(b) The medical officer treating or observing the case will record each periodic follow-up in section V of SF 602. The medical officer who treats and follows up cases of sexually transmitted diseases will keep suspense files or appointment records needed to ensure that current cases are observed long enough.

.(c) The medical officer treating the patient closes the record by signing section VI of SF 602. After closing, SF 602 will be kept as a permanent part of the HREC. The record will be closed if treatment and follow-up have been completed with satisfactory results, if the patient is separated from active service, if the patient deserts or is otherwise lost to military control, or if the patient dies.

.(d) A record will be reopened for relapse (in which case, the record filed in the HREC will be used for needed information; entries about the case will be continued on SF 602) or reinfection. (If reinfection occurs before the record is closed, the current record will be continued. In addition, the follow-up will be extended for an additional period of

observation. Interim progress notes will be entered on SF 602 and will give all pertinent information and state a new diagnosis. They will also cite the clinical and laboratory data that prove the new diagnosis. If reinfection occurs after the record is closed, a new record will be prepared.)

.(e) If the patient and his or her HREC are transferred before the record is closed, the medical officer of the losing command will put a statement in the HREC that the person needs more follow-up studies. This statement will be fastened with SF 602 at the top of the inner right side of the HREC. Once noted by the physician providing the follow-up care, SF 602 will be put in its normal place in the record.

.(11) DD Form 2795 and DD Form 2796. These forms are used to record the results of

pre- and post-deployment health assessments of deployed military personnel, and may be used for deployed civilians. If used, these forms will be prepared according to paragraphs 5–32*a* and 5–35*a*.

5–22. Mental health records

When outpatient mental health treatment is recorded in military files, the following notation will be made on SF 600: "Patient seen, refer to file number 40–216k1" (mental health records (adults)). (See AR 25–400–2 and table 3–1 of this regulation.)

5–23. Access to health records

All personnel having access to HRECs will protect the privacy of medical information. (See chap 2.) The extent of access allowed to certain personnel is described in *a* through *e*, below.

.a. Medical personnel. AMEDD personnel are allowed direct access to HRECs for purposes of diagnosis, treatment, and the prevention of medical and dental conditions. They also have access to work for the health of a command and to do medical research.

.b. Military members. If a military member requests information from his or her HREC or copies of the documents in it, it will be given to him or her. If the record is a special category record, see AR 340–21, paragraph 2–5. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized.

.c. Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections in accordance with AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections in accordance with AR 50–5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect. Inspectors do not have unlimited access to ASAP–OMRs in accordance with 42 USC 290dd-2.

.d. Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the HRECs of personnel killed or missing in action. They may have access to extract medical and dental information needed by their service.

.e. Other nonmedical Army personnel. Nonmedical personnel may need information from a person’s HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General’s Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations. Official requests for specific information from the HREC or copies of documents in it will be sent to the MTF Patient Administration Division, DENTAC commander, or RC record custodian, who will determine what information will be supplied by the MTF. (See para 2–3*a*.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, in accordance

with AR 50–5 and AR 50–6, are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authorities. Access to ASAP–OMRs is limited. (See guidance in 42 USC 290dd-2.)

5–24. Cross-servicing of health records

This regulation and similar ones in the other Services allow and direct cross-servicing of HRECs. Procedures for maintaining and transferring Navy and Air Force HRECs are similar to those described for Army HRECs.

.a. When members of other services are attached to Army MTFs or DTFs for primary care, the MTF or DTF will assume custody for their HRECs. These HRECs will be maintained as discussed in this regulation.

b. HRECs not sent with Navy and Air Force patients will be requested when needed for treatment. Similarly, Army HRECs will be sent to Navy or Air Force HREC custodians when Army personnel are given care by MTFs or DTFs of those Services.